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Homelessness in Wisconsin: Current Situation and Future Prospects

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A Coordinated Approach to Housing the Homeless Mentally Ill

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Homelessness in Wisconsin in the National Context

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Homelessness in Wisconsin in the National Context

Homelessness in Wisconsin from 1838 to 1870

In the initial period of European settlement in Wisconsin makeshift housing was commonplace. Indeed the "Badger State" term derives from a description of one type of temporary housing. During the early settlement phase there was no public responsibility for the housing or sustenance of the poor or the pauper. The able-bodied person who was 'willing to work' was presumed to be able to support themselves and their family in normal circumstances. Personal disasters might elicit aid from neighbors and friends, or as was the case in general economic downturns, people simply left and moved to more promising areas.

The first Legislative act for the provision of relief and support for the poor in Wisconsin was passed in 1838. This Territorial Act placed responsibility for relief with the county board commisssioners. As towns and counties were organized, provision for the destitute was seen as an essential element in local government. Almost without exception, responsibility for relief was adopted within the first year (indeed many towns and counties had methods of relief prior to formal formation) (Carver, 1917). In 1849 the new State of Wisconsin legislated for both county and town systems of relief. The mixed pattern of relief administration has continued almost to the present time.

Early relief provision in Wisconsin was established locally following traditional attitudes and policies derived from the English Poor Law system of relief. In this system a person was attached to a specific place [a Parish] and it was the responsibility of the parish to regulate the welfare of its indigent population (Ribton-Turner, 1887). The eastern colonies and later the frontier states inherited the "local" pattern of relief and punishment for the indigent and vagrant classes (Riis, 1890). Almshouses (and outdoor relief) were provided for the deserving indigent, local poorhouses and workhouses were for the less deserving and the vagrant. In Wisconsin the civil units of towns and counties substituted for the English parishes.

Homelessness and vagrancy in Wisconsin derived from the same sources as in the eastern colonies and England: poverty, disability, age and choice. Public and private responses also followed the eastern and English patterns, with private charities opening almshouses and soup kitchens and some public relief. The dynamic economy and westward expansion provided opportunities to the poor of the eastern cities which prevented the build up of large destitute urban populations until the later part of the 1800's. Wisconsin and other frontier states absorbed, at least for a while, labor that was surplus on the eastern coast (Riis, 1890). This workforce was important in the early labor intensive period of settlement. (The westward transfer of labor also included destitute and orphaned children sent as indentured laborers to Wisconsin farms.)

The treatment of people who could not support themselves varied radically depending on public and administrative attitudes toward the cause(s) of an individual's dependence. In the initial period of Wisconsin settlement a considerable degree of social scanction was associated with receiving public relief. For example, town boards were required to report each year, the name and amount of support received by each person or family. The aim of this requirement was to keep the number of applications as low as possible (Carver, 1917). Some town boards took the requirement one step further by requiring applicants to appear at a public hearing in front of the whole town board and to present reasons why they should be granted aid. When aid was granted, it was frequently linked to required work (usually on the town roads). The amount of aid was usually left to the discretion of the town officers.

A number of counties also administered relief in the early period of statehood. The usual case was that the town chairmen would decide (in County Board meeting) that they wished the county to administer the relief program. In practice there was considerable shifting of responsibility and hence confusion as townships sought (usually for financial reasons) to have the county take over the costs of relief yet to retain control at the township level.

The situation of the indigent and dependent population in Wisconsin was not significantly different than that in many states in the 1860's. In addition to the state prison (established in 1850), there

were several institutions established for segments of the dependent population:

Population	Established
Blind	1850
Deaf	1854
Insane	1854
Delinquent Boys	1857

The indigent who did not fall into these categories (and some who did) were usually confined to local poorhouses. While the state institutions were generally overcrowded and under-staffed, appaling conditions existed in the local poorhouses. The county and town poorhouses were designed to discourage use. Located in isolated areas, their inhabitants faced poor food and lack of beds, sanitation and even fresh water. Confined within these poorhouses were indigent men, women, and children, and persons with various disabilities.

Homelessness in Wisconsin from 1870 to 1930

In the aftermath of the dislocations of the Civil War, Wisconsin like many other states undertook several studies aimed at reorganization and reform of its public welfare efforts. In 1871 the newly established Board of Charities and Reform began systematic investigations into the conditions in all state institutions as well as town and county facilities. The conditions discovered were described as "filthy", "disgusting", "offensive", with "beds full of vermin", "walls clotted with blood", "urine running over the floor", and "a disgrace to the state".

The reform movement led to the establishment of several specialized programs to serve particular subpopulations within the general welfare program. There appear to have been three threads running through this reform movement. First there were efforts to reform the conditions prevailing in the poorhouses themselves. Unfortunately, although uniform standards were developed for poorhouses, the Board of Charities and Reform was only able to recomend changes. Some counties and towns simply ignored the recomendations. Second, there was a often voiced concern that individuals with disabilities be seperated from the "pauper class". These concerns stemed from the perceptipn that people with disabilities were deserving of help. Indigent yet deserving individuals were to be well provided for, while the pauper was to be erradicated. Finally, there were pressures to expand the classes of individuals who could call on the state for support as a

right. In effect, the reform movement of the 1870's sought to improve the lot of those people identified as 'deserving' and to extend the definition of deserving.

In 1878 and 1881 the "Wisconsin System" of county asylum care for the chronically mentally ill was introduced in an effort to relieve the overcrowding and mixing of people with mental illness, mental retardation, and the "chronic insane" at the state mental hospital, poorhouses, county jails and insane asylums. In the 1880's 18 county asylums were constructed, and by 1900 a further 9 had been added to the county asylum system. The mental health system (in the 1880's and 1890's) thus consisted of;

Institution	Population Served
State Hospitals	Acute or curable mentally ill.
County Asylums	Chronically mentally ill.

Many mentally retarded persons who were technically excluded from these facilities were classified as "insane" and committed to county asylums. However, as the cost increased, the state (in 1894) responded by forcing counties to strictly enforce eligibility criteria (thus reducing state reimbursement). The net result was a surge of mentally retarded people who were admitted to poorhouses in the next three years (Rugg, 1983). This example of progressive reform improving conditions for some, excluding some, and the service system adjusting to the change has been repeated several times. In general, the aim of separating the deserving from the undeserving has been

conditioned by the cost of serving all those defined as deserving.

As previously noted, as the state began to serve segments of the population previously unserved or underserved there was increasing advocacy for expansion of those who would be eligible for services; mentally retarded children, disabled aged, and persons (particularly children) with multiple disabilities. While eligibility was expanded, the division of the indigent population into deserving and undeserving clearly placed vagrants in the undeserving class; it would be several decades before the alcoholic or the day laborer would be seen as deserving of some assistance (Allen, 1903).

The expansion of services and eligibility in the period from the 1890's to 1930 was heavily influenced by the current views and practices of social service professions. For example, the eugenics movement with its view that 'genetic defectives' were likely to become paupers, criminals and insane, directly influenced the type of care directed toward those groups. Wisconsin, along with many other states, introduced sterilization to prevent the transmission of the genes of persons who had undesirable traits. (see Komisar, 1977 for a history of the interplay between reform movements, welfare programs, and increasing bureaucratization).

While the State of Wisconsin moved into a more active position with regard to the dependent population, the growing urban areas presented a new phenomena for Wisconsin-- the emergence of urban concentrations

of poverty. In the thirty years prior to the turn of the century slums emerged in the larger towns and cities of Wisconsin. By the 1890 Census it is possible tc identify definite areas of cities were concentrations of poverty and low quality housing coincide. The Census primarily counted the domiciled population, but as the numbers of the poor increased, concentrations of homeless and near homeless individuals and families could be observed living in the open, in shanty towns or boarding houses (Booth, 1890 gives the U.K. comparison).

Relief agencies focused on these areas, and their activities drew still more people who were homeless and discouraged competing activities. Here we see the outcome of public policies which forced people who were homeless to leave specific locations, the establishment of relief agencies in areas of concentration of the poor, and the focus on relief of current crisis needs (food, shelter), rather than long term solutions (Gault, 1914).

Homelessness during the Depression, War, and Recovery

The Great Depression led to widespread poverty in Wisconsin which exposed the inherent structural problems of administering the Wisconsin system of relief. The state became involved through the provision of funds for public relief employment. This was the first time that local units were directly aided by the state for the provision of public assistance. It is also notable that the state treated local units differently according to the amount of need and the local unit's ability to meet that need. Federal funds for relief ended in 1936 and was quickly followed by a reorganization of relief activities In general, counties became the focus of relief (42 counties), while local units remained in control in 14 counties and in 15 counites local units formed groups to administer relief.

One major effect of the Great Depression was the Citizen's Committee or Public Welfare (1937). The Committee made many recomendations such as the transfer of relief activities to the counties, state-funded support for transients, and a work based relief program for the unemployed. The recomendations of the committee had little effect and the fragmented administrative structure continued.

The upturn in the economy during the Second World War reduced the destitution due to unemployment. The burden of relief was not entirely eliminated due to the number of people who were unable to

work or were transient (Brantner, 1959). The new Social Security system did not really grow substantially until after the end of the war, so that most relief depended on local or state resources.

In the post-war period, pressures on the relief structure stemmed primarily from the growth in destitution due to unemployment. In the 1950's the transient was still vulnerable to arrest and vagrancy charges. The person with mental illness was also vulnerable to institutionalization which was seen as the most appropriate care for many types of mental illness (Bogue, 1963). This is also the period of the introduction of major efforts directed toward the treatment of alcohol abuse as a disease rather than a criminal offense. The change in attitude toward the abusive use of alcohol led to confinement in treatment facilities rather than jails (Fry and Miller, 1975). Thus several segments of the traditional homeless population were removed from the destitute group by being confined or moved on to another jurisdiction.

Homelessness in Wisconsin : The Last Twenty Years

Nationally in the 1960's the effects of the post World War II housing construction boom and flight from the central city were becoming apparent in many cities. Deteriorating housing and inner city unrest contributed to a major effort to renew the central cities. Widespread demolition of substandard buildings eliminated much of the housing which would normally have provided shelter to those persons in extreme poverty (Miller, 1981).

By the mid 1960's the relative prosperity of the period had contributed to a decline in the number of people who were homeless and consequently the notion of urban renewal of skid row was seen as a practical method of dealing with the homelessness problem (Bogue, 1963). It was thought that by removing the cubical and SRO hotels, people who were homeless would move to better accomodations (which, in theory, had been left vacant by households leaving the city). However, at the same time as skid row was being "renewed" other housing was being demolished or upgraded. Federal and city building standards required removal or renovation of substandard housing. In the 1960's these standards became progressively more stringent. The net result was a drastic reduction in availability of affordable housing for those in extreme poverty.

The upgrading of housing conditions and building codes were not limited to the large urban centers. Rural communities also enacted

tighter building codes, often in response to state and federal aid programs. Rural areas in Wisconsin were faced with increasing expectations from their residents and increasing requirements from state and federally mandated programs. Although many rural areas lacked the financial-ability to pay for these programs, building and zoning requirements were 'cost free' and sometimes brought additional funds.

The growth in the number of people who were homeless that occurred in the 1970's is not surprising considering the policies being applied during the period (Hombs and Snyder, 1982, Hopper, 1985). The urban renewal policy removed much of the lower end of the housing market in central cities (Downs, 1983, Kasinitz, 1984). The very poor resident could not afford or function in the remaining housing without a significant increase in social and economic supports. While economic and social support programs did increase, they were not sufficent to ensure the housing of the poor (Miller, 1981, Auletta, 1983, Norton, 1983).

Housing and income policies were not the only policies which contributed to the rise in the number of people who were homeless in the 1970's (Garrett and Bahr, 1976). The deinstitutionalization the mentally ill population which began in the mid-1960's reached its peak in the early 1970's. Some of the deinstitutionalized population became homeless and swelled the number of people on the streets (Braun et. al., 1981, Friedman, 1983, Hope and Young, 1984). These

individuals also fundamentally altered the characteristices of the homeless population (Bachrach, 1984).

For most of U.S. history the homeless population had had two major components: the economically disabled (the working poor and destitute) and the physically disabled (including the alcoholic) (See Bahr, 1973, Bahr et. al., 1976, and Cohen and Sokolovsky, 1983, for modern sociological treatments of this segment of the population). These two components fluctuated in size with public attitudes and the state of the economy (Bassuk, 1984). The mentally ill population thus added another major component to the homeless population, a component that service agencies were often completely inexperienced in dealing with in a community setting (Chmiel et. al., 1979, Smith and Hanham, 1982, Dear and Taylor, 1982, Burnett and Moon, 1983). Initially the person with chronic mental illness who become homeless had been deinstitutionalized and tended to be middle-aged (Reich and Siegel, 1978). More recently, younger persons who have been denied admission have been added to the population (Segal et. al., 1977, Hopper et. al., 1982, Goldman, Adams and Taube, 1983, Lamb, 1984). Thus, the component of the homeless population that is mentally ill has within it considerable variations in past experience and contact with the mental health system (Williams, 1977, Bachrach, 1984, APA, 1984,, Baxter and Hopper, 1984).

The late 1970's and early 1980's have seen the addition of more and more families to the homeless population (Cuomo, 1983, Stern, 1984).

The rapid rise in rental rates, coupled with condominium conversions and the virtual elimination of public housing construction has squeezed many families out of the housing market (Dolbeare, 1983, Downs, 1983). These families have placed additional burdens on emergency housing services. Like people who are mentally ill, families have special needs that traditional shelter providers have not been accustomed to dealing with in the past. Another group which experience difficulties in the housing market is ex-offenders. These persons are disadvantaged in the labor market and thus tend to have low incomes while also experiencing discrimination in the housing market. Providing housing services to these individuals requires both specialized service delivery models and personnel (Greenwood, 1975). This mix of needs within the homeless population has emerged as one of the major difficulties in delivering services (Cuomo, 1983, Stern, 1984).

By the early 1980's, the size of the homeless population of the U.S. was variously estimated to be under 1 million (HUD) to as high as 2 million (Hopper et al., 1982, Leepson, 1982). While the absolute size of the population is a subject of considerable debate, there is a consensus that people who are homeless have significant problems. Approximately 40% of the homeless population are heavy users or abusers of alcohol, 30% suffer from chronic mental illness, and virtually 100% are destitute (Freeman et.al., 1979, Depp and Ackiss, 1983, Cuomo, 1983, Stern, 1984). The U.S. Congress has had several hearings as the homeless problem has emerged. These provide the best

sources for many of the individual city studies (U.S. House of Representatives, 1983, U.S. House of Representatives, 1984).

Wisconsin has not avoided the increase in the numbers of people who are homeless. While experiencing lower levels of poverty than the nation as a whole, Wisconsin nonetheless has significant numbers of persons in poverty (Kanskie, 1985). The same trends that are involved in the national increase in homelessness are also at work in Wisconsin (Salerno et. al., 1984, U.S. Conference of Mayors, 1984). Removal of low income housing, deinstitutionalization, and inadequate poverty support payments for the very poor have all been documented in Wisconsin (Salerno et. al., 1984, Rosnow et. al., 1985, Stapleton Concord, 1985). While some community support programs in Wisconsin are among the best in the nation, others are less well developed (Test and Stein, 1978). The studies of the homeless mentally ill population in Wisconsin indicate rather extensive contact with the mental health system, but also a significant level of disengagement (Rosnow et. al., 1985, Stapleton Concord, 1985, Rosnow et. al., 1986).

It is the overlapping problems of the constituents of the homeless population that present difficulties for service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. Even the simple provision of shelter becomes a problem because rules which were normative in former years now present difficulties in the light of the changed needs of the homeless

population (Segal and Baumohl, 1980).

The rapid growth in the number of people who are homeless further exacerbates the problem. Because there has been a lag in the allocation of funds to meet current needs, shelter and other service providers have been swamped with demands for shelter, food, job assistance, clothing, health care etc. (Parker, 1984). Many agencies are devoting the majority of their budgets to emergency care, making little provision for long term projects which could bring the homeless in off the streets permanentl (Stoner, 1984, U.S. Government Accounting Office, 1985).

Advocacy efforts on behalf of the homeless populatior were first directed toward documenting the problem (Priest, 1975, Rousseau, 1981). Initial studies aimed at getting accurate counts of the number of people on the street and providing sufficient shelter space. Later there were concerted efforts to use whatever legal or other resources were available to obtain and extend the rights of the homeless population (Pina, 1983, Fabricant and Epstein, 1984). The activation of public and private resources that has occured over the last five years has attempted to prevent deaths from exposure and move toward more long run solutions (Stoner, 1984). This course of events has not been universally supported as some have advocated no public involvement beyond stimulation of the economy to produce a general increase in income in the nation (Kondratas, 1985).

In many cities the immediate crisis has been met, at least in part, so that there is now the possibility of planning for more than emergency shelter (Leaf and Cohen, 1982, Rooney, 1980). While identifying the dimensions of homelessness remains an ongoing concern, many agencies and research studies are now turning to considerations of longer term solutions (Maz, 1983, Segal and Baumohl, 1980).

Growing recognition that people who are mentally ill may be particularly vulnerable to becoming homeless has led to a range of initiatives at local, state, and national levels. Just as there is no simple answer to how the problem developed there is no simple solution (Watson, 1986, Segal and Baumohl, 1980).

Preservation of existing low income housing is a critical aspect of the solution to homelessness (Watson, 1986, Lincoln, 1980, Cuomo, 1983). Recognition that SRO housing may have to be preserved and even constructed has led to several models (Connor, 1983, Marcus, 1981). More structured living arrangements that fall short of group homes have be sucessfully used in some localities (Otto and Orford, 1978). Highly structured living arrangements also seem to be sucessful for some persons (Wallich-Clifford, 1976).

These housing initiatives are only one part of the solution. Flexible approaches to treatment, and treatment that forms part of an integrated program are seem by most researchers as essential (Rhoads, 1981, APA, 1985, Erickson and Wilhelm, 1986).

Service delivery to vulnerable individuals as well as those already on the street is likely to involve rethinking of delivery models. There is a need to re-examine models, particularly with respect to the multiple problems that people who are homeless often have to deal with on a daily basis (APA, 1985, Erickson and Wilhelm, 1986).

While some agencies are already deeply involved in service delivery to people who are vulnerable or actually homeless, a wider involvement will probably be necessary for long term solutions to be sucessful (Stoner, 1984, U.S. Government Accounting Office, 1985). Agencies and groups not normally associated with people in great distress will likely be crucial because their actions can have profound effects. Housing authorities, community mental health agencies, public health centers, public and private welfare agencies and federal, state and local governments are some of the broad group of actors that have a role in solving the problem of homelessness (U.S. House of Representatives, 1983, U.S. House of Representatives, 1984). Any long run solution to the problem will thus necessarily rest on the development of consensus among service agencies and a range of public and private individuals and groups (Cuomo, 1983, Stern, 1984).

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Annotated Bibliography on Homelessness

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Annotated Bibliography on Homelessness

The following annotations cover both current and historical materials. The annotations are intended to provide a portal of access to the rather scattered literature on homelessness. The annotations are drawn from author abstracts as well as original annotations.

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Extensive review of the role of mental illness and deinstitutionalization in the increase in homelessness in the late 1970s and early 1980s. The authors note the failure of some CSP programs for some people who then are at increased risk of homelessness. This book remains controversial in that among the recommendations was a "reinstitutionalization" proposal, and the general "medical model" viewpoint expressed by some authors in the book. Some have pointed to the "sick" or "deviant" attitude that critics have seen as underlying the attitude toward the individual who is homeless.

Arce, A.A., Tadlock, M., Vergare, M.J., & Shapiro, S.H. (1983). A psychiatric profile of street people admitted to an emergency shelter. Hospital and Community Psychiatry, 34(9), 812-817.

This relatively early profile of the mental health of people who are homeless focuses on individuals who were identified as "crazy" by shelter providers, etc. The identification of relatively high rates of mental illness in this research is a result of the pre-screening by shelter workers. While some 85% of the subjects were judged to have some level of illness, it is notable that 15% of those prejudged by shelter workers as "crazy" were found to have no diagnosable mental illness.

Auletta, K. 1983. The Underclass. New York: Vintage Books, 348 pp.

The author seeks to find out who are the people behind the expanding crime, welfare, and drug statistics--and the rise in antisocial behavior that seems to be occuring most

American cities. The author notes that among students of poverty there is generally widespread agreement that a comparatively distinct black and white underclass does exist. Determining the size of America's underclass depends on one's definition of the term. If one includes all those officially classified as poor, according to the federal census, in 1980 there were 29.3 million Americans living at the poverty level: 19.7 million were white, 8.6 million were black, and 3.5 million were Hispanics. However, most students of poverty distinguish those who are temporarily poor from those more or less trapped in long-term poverty; it has been suggested that approximately 30% may be described as "acutely poor."

Bachrach, L.L. (1984). The homeless mentally ill and mental health services: An analytical review of the literature. Rockville, MD: National Institute of Mental Health.

Summarizes much of literature on mental illness and homelessness. Emphasis is on evaluations of "medical model" approaches. Much of the material reviewed here is also presented in APA (1984).

Bahr, H. (1973). Skid row: An introduction to disaffiliation. New York: Oxford University Press. [HV4505 .B34]

Explores skid row from the point of view of social pathology. Traces the chains of broken contacts (family, job, church, etc.) that lead to social vulnerability. This work represents the modern expression of the view of destitution as the result of social disorganization and breakdown.

Bahr, Howard M. and Garett, Gerald R. (1976) Women alone: the disaffiliation of urban women. Health, Lexington, MA, 207 p.

Data gathered from homeless women, collected from residents of the women's emergency shelter (New York City) were compared with reports of detachment from society among men as part of the Columbia Bowery Project in a study of urban disaffiliation. Disaffiliation is defined as detachment from society characterized by the absence or attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures. It is reported that undersocialization, anomie, generational retreat, economic marginality, and occupational mobility are not predictors of disaffiliation for the women, but that a multivariate analysis reveals that age is the dominant predictor of affiliation. In comparison to the men, the shelter women were younger, poorer, more apt to come from broken homes, and to have been married. Both groups lacked contact with family and friends. Men misperceived, and therefore underreported, their drinking. It is concluded that the independent women are disaffiliated because of present circumstances which can be altered to facilitate reintegration.

Bassuk, E.L. (1984) The homelessness problem. Scientific American, 251(1):40-45, July.

> During the winter of 1983/1984, more Americans were homeless than at any time since the Great Depression; the National Coalition for the Homeless put the 1983 figure at 2.5 million, an increase of half a million over the preceding year. There are, unfortunately, no reliable data on the homeless, the author notes, even though they have always been in great number in American cities. Anecdotal evidence has indicated that in the decades prior to the 1970s, most of the homeless were unattached, middle-aged, alcoholic men--inhabitants of Skid Row. Since about 1970, the population seems to have been growing progressively younger. And a more important change may be taking place: an increasing number--possibly even a large majority--of the homeless suffer from mental illness, ranging from schizophrenia to severe personality disorders. Shelters for the homeless find themselves with the impossible responsibility of replacing not only the almshouses of the past, but the large state mental institutions, as well.

Baxter, E., and Hopper, K. (1984). Trouble on the streets: The mentally disabled homeless poor. In J. Talbott (ed), The chronic mental patient: Five years later pp. 49-62. New York: Grune and Stratton.

> While the emphasis is on NYC, this paper presents the core of the advocacy position that the homeless mentally ill person is a victim of inept and uncaring bureaucracies that place "rules" and financial stringency above the human consequences.

Bennett, D., and Morris, I. (1983). Deinstitutionalization in the United Kingdom. International Journal of Mental Health, 11(4), 5-23.

> Presents a description of deinstitutionalization in the U.K. Remarkable in the number of parallels in the issues (impacts on neighborhoods, families, community support programs, costs) that occurred in the UK and U.S.A.

Bogue, D.J. (1963). Skid row in American cities. Chicago: University of Chicago.

> Classic study of skid row which formed a major intellectual foundation for the removal of SRO's flop houses, etc. in the Urban Renewal program of the 1960's. The focus is on the deviance of the residents of skid row, methods of control, reform and elimination. Notable are the views that there are few women on skid row and that the mentally ill are identified (by police counts, etc.) and removed to hospitals.

Booth, W. (1890). In darkest England and the way out. London: Salvation Army.

A significant background resource in that much of the Salvation Army approach is illuminated by Booth's description and emphasis of the problem. The book's strong position on detention should be understood in the light of the then current vagrancy laws (i.e., vagrancy as a status offense).

Brantner, J.P. (1959). Homeless men: A psychological and medical survey. Unpublished doctoral dissertation, University of Minnesota. Ann Arbor U Microfilms [Microfilm AC-1-59-12533]. Dissertation Abstracts, 19(11), 3018-3019.

A useful historical comparison. The author notes the major health problems of long term alcohol abuse and deprivation.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J.E., Johnson, S., & Shore, M.F. (1981). Overview: Deinstitutionalization of psychiatric patients; A critical review of outcome studies. American Journal of Psychiatry, 138(6), 736-749.

Examines the successes and failures in deinstitutionalization. Identifies behavioral problems on the part of patients and mismatches with providers as the major sources of failure. The author concludes that successful deinstitutionalization depends on availability of appropriate community care.

Burnett, A., & Moon, G. (1983). Community opposition to hostels for single homeless men. Area, 15(2), 161-173.

Community opposition to a homeless hostel [shelter] derived from the neighbor's fear of alcohol, violence and destitute individuals being on the street. Although this is an English example it provides a detailed case study and a strong parallel to Dear's (1982) description of opposition to community mental health facilities.

Chicago Coalition for the Homeless. (1983). When you don't have anything. Chicago (P.O. Box 2751, Chicago, IL, 60690): Author.

Profile of homeless persons in Chicago in 1983. This study interviewed people who were homeless and gives both demographic and social information. Provides the "regional primate city" comparison for Wisconsin.

Chmiel, Andrew J., Akhtar, Salman, and Morris, Juanita. (1979) The long-distance psychiatric patient in the emergency room: insights regarding travel and mental illness. International Journal of Social Psychiatry, 25(1):38-46.

The motivational, demographic and clinical characteristics of individuals who seek psychiatric help at facilities located a great distance from their places of residence is discussed. Two groups (the first group is constituted by persons who, owing to their concerns with the social stigma of mental illness or driven by the desire for a magical

solution to their problems, purposely undertake the journey to a distantly located psychiatric center and the second group consists of vacationers, hitchhikers, and skid row individuals) are identified. The results indicate that the long distance patients had a higher incidence of schizophrenia and alcohol related problems accounted for by the second group of long distance patients.

Cohen, C.I., & Sokolovsky, J. (1983). Toward a concept of homelessness among aged men. Journal of Gerontology, 38, 81-89.

Provides a modern theoretical sociological statement on the causes of homelessness. The authors emphasize disaffiliation as the root cause rather than inherent defect (such as unwillingness to work).

Collin, R.W. (1984). Homelessness: The policy and the law. Urban Lawyer, 16(Spring), 317-329.

Connor, J. (1983). Sheltering the homeless - for a model single room occupancy (SRO) for the homeless in Detroit. Paper presented at the hearing on Homelessness in America,. (Clare check)

An early proposal for a model SRO. This proposal has been frequently cited and debated in discussions as to the advisability supporting SRO accommodations. The paper presents the rationale adopted in many cities [San Francisco, NY, etc.].

Crystal, S. (1984). Homeless men and Homeless women: The gender gap. The Urban and Social Change Review. 17(2):2-6

Cuomo, M. (1983). 1933/1983--Never again: A report to the National Governors' Association Task Force on the Homeless. Albany, NY: State of New York, Executive Chamber. Reproduced in Subcommittee on Housing and Community Development (1984), pp. 353-443. [HV4504 .C86 1983]

This national study laid the foundation of the Governors' Association efforts on behalf of the homeless.

Dear, M.J. and S.M. Taylor. (1982). Not on Our Street: Community Attitudes to Mental Health Care. London: Pion.

A social science study of the impact of community mental health services on the local community.

Depp, F.C., and Ackiss, V. (1983, July 19). Assessing needs among sheltered homeless women. Paper presented at the conference "Homelessness: A Time for New Directions," Washington, D.C.

Reports on women using The House of Rath (Washington, D.C.). While many (95%) of the women had been treated for mental illness, higher proportions self-represented psychopathology (65%) and shelter staff believed (94%) to be in need of psychiatric evaluation and treatment. The shelter appears to

be functioning as an element in the community mental health system.

Dolbeare, C. (1983). The low-income housing crisis. In C. Hartman (Ed.), America's housing crisis: What is to be done? Boston: Routledge & Kegan Paul.

Presents statistics on the recent decline in low-income housing and identifies the causes as; demolition (Urban Renewal, slum clearance), renovation (gentrification and resident upgrading) and conversion (to condominiums and offices). Notes that the prospect for significant private construction is limited by the relative unprofitability of low income housing when compared to other types of housing.

Downs, A. (1983). Rental housing in the 1980s. Washington, D.C.: Brookings Institution.

The author argues that low profitability limits rental accommodation supply while higher housing costs places increased pressure on the rental market from those who can not buy. The net result is low vacancy rates, higher rents and a growing inability of very low income households to afford housing.

Erickson, J. Wilhelm, C. (eds). (1986). Housing the Homeless.

A book of readings covering 1980-85. Several of the most significant papers of this period are collected in this book. There is a balance between papers by advocates and more pragmatic public policy approaches.

Fabricant, M. and Epstein, I. (1984) Legal and welfare rights advocacy: complementary approaches in organizing on behalf of the homeless. Urban and Social Change Reivie, 17(1):15-19, Winter.

A case study of a welfare advocacy effort on behalf of the homeless in Elizabeth, New Jersey. On the basis of this and other efforts, the complementary elements of legal and welfare rights advocacy are considered. In working with the homeless, the authors note, critics of legal advocacy have claimed that it is too time-consuming, too limited by the minimal standards of economic entitlement of present laws to deal effectively with root causes of the problem. Yet critics of welfare rights advocacy have argued that a case-by-case approach which exclusively provides immediate aid is too narrow in scope, fails to change legal and administrative frameworks, and that laws and bureaucratic procedures which provide the initial organizing opportunity become more constrained once fiscal pressure is applied. The authors suggest that legal and welfare rights are not mutually exclusive tactics, but instead complementary approaches which can address the immediate service needs of the homeless and provide a firm foundation for organizing in their behalf.

Foucault, M. (1968). Madness and civilization. New York: New American Library.

Although not intended as a discussion of the homeless mentally ill, this volume contains much historical information. Emphasis in on Europe, but because the U.S. inherited many of the policies developed in Europe this book is very useful background.

Freeman, Stanley J., Formo, Anton, Alampur, A. Gopala, Sommers, and A. Frank. (1979) Psychiatric disorder in a skid-row mission population. Comprhensive Psychiatry, Oct., Vol. 20(5), pp. 454-462.

Researchers administered a standardized psychiastric screening interview. Approximately 35% of the subsample of 60 SS could be categoup that made extensive use of a wide-range informal network of services.

Friedman, E. (1983). The light that failed: Psychiatric deinstitutionalization has betrayed its promise. Hospitals Journal of the American Hospital Association, 57(16), 88f.

Posits that deinstitutionalization movement promised more than it could possibly provide. Lack of funding further limited the potential of the movement, but even with higher levels of funding deinstitutionalization would not have been a cooup that made extensive use of a wide-range informal network of services.

Friedman, E. (1983). The light that failed: Psychiatric deinstitutionalization has betrayed its promise. Hospitals Journal of the American Hospital Association, 57(16), 88f.

Posits that deinstitutionalization movement promised more than it could possibly provide. Lack of funding further limited the potential of the movement, but even with higher levels of funding deinstitutionalization would not have been a complete solution.

Fry, Lincoln J. and Miller, Jon. (1975) Responding to skid row alcoholism: self-defeating arrangements in an innovative treatment program. Social Problems, 22(5):675-688.

The study identifies ambiguous and competing goals, conflicting vested interests, conflicts over organizational resources, and a lack of treatment technology as major sources of ineffectiveness in an innovative alcoholism treatment program located in a skid row mission. The agencies sponsoring this venture contributed to these problems, especially by their lack of planning and the large public expenditure actually diverted the treatment program from servicing one segment of its target population and indirectly contributed to the skid row alcoholism problem by introducing men to the area who might not otherwise have

found their way there.

Garrett, Gerald R. and Bahr, Howard M. (1976) The family backgrounds of skid row women. Signs: Journal of Women in Culture and Society, 2(2):369-381.

The etiology of homelessness and excessive drinking of women who were both homeless and alcoholics were investigated. Data were gathered from life history interviews with 32 homeless women at a women's emergency shelter in New York City's bowery area and 199 male clients at an institution to which aged and ailing bowery men are voluntarily committed. Forty-four percent of the shelter women were black compared to 25% of the men. The women were more likely to be nativve born and better educated. Over half of the women, compared to 1/3 of the men, were reared in families where one or both parents were missing. Over 2/3 of the men cited a parental death as the reason for their broken home while the same percentage of women indicated a parental divorce, separation, or desertation. None of the respondents was living with a spouse at interview time but for most of those who had been married at least once, the marriage ended in separation or divorce. Over 75% of the women had been married compared with less than half of the men. Reported marital disagreements over the drinking of either spouse and over inlaws were significantly higher for the women. More than half of the women said that infidelity was a marital problem. The women were more likely to have large families than the men. It is concluded that the path leading to homelessness appears to be both qualitatively and quantitatively different for women than for men and that women from broken homes are in fact overrepresented among shelter women in comparison to other women as well as with skid row men. It is suggested that failure in marriage may be a key variable in explaining the "skid careers" of women while among homeless men it seems to play a minor role.

Gault, R.H. (1914). Pathologic vagrancy. Journal of Criminal Law and Criminology, 5, 321-322.

This book traces the development of working class housing, subsequent attempts at reform and regulations. Along with histories of social welfare tracing development of housing is an essential element in the background of modern homelessness.

Giesbrecht, Norman Abe. (1981) Changes in the drinking patterns of, skid row alcoholics. (Ph.D. Thesis) Dissertation Abstracts International, 41(7):3288-A (not available from Univ. Microfilms).

The concomitants of abstinence and controlled drinking among current and former skid row ineeriates were examined to study the normalization of deviants. Data were gathered from retrospective accounts of former and current male skid row inebriates on three main areas: current drinking

behavior and major changes since the onset of heavy drinking, changes in other areas of experience, and the assessment of factors giving rise to abstinence or control. A strong relationship was found between current drinking status and either stakes in conformity or treatment experiences. The currently inactive drinkers were found to have a less negative view of how others had responded to them when they had been drinking heavily, were more likely to have been persistent in seeking out treatment contacts at that time, and more likely to have a positive assessment of their treatment experiences.

Goldman, H.H., Adams, N.H., & Taube, C.A. (1983). Deinstitutionalization: The data demythologized. Hospital and Community Psychiatry, 34(2), 129-134.

Reviews the status of deinstitutionalization and notes the following patterns; more people are denied admission and those admitted to hospitals are staying shorter periods leading to more people with mental illness living in the community.

Greenwood, Anthony A. (1975) Langley House Trust and the Problem of the Homeless Ex-Offender. Prison Service Journal (Reddich), 20:5-8.

A 240 bed community for homeless exoffenders is described in terms of goals, functions and limitations. The 12 house trust offers a caring, family like home where a man is asked to make a commitment in becoming a member of the family. Houses fall into three groups: halfway houses, fully supportive communities, and homes for retirement age men and others with no further work expectancy. The close relationship of each house with the probation service is discussed, and measures of success are reviewed. Records from one house indicate that after 5 years of existence, 43% of the men who had been residents settled down and took an honorable and stable place in society. Rejection of postsentence support by about 80% of homeless men leaving prison is noted, and reasons are posited for this reticence.

Gude, John. (1977) Accommodating the single homeless. (1977) Social Work Today (Birmingham), 8(34):10-13.

The Nottinghamshire lodging scheme is described with an account of its 4 year history. Although there have seen some difficulties in cultivating and retaining those landladies who are prepared to provide for the special needs of a group of single homeless exoffenders that includes alcoholics, severely nurotic and psychiatrically ill men, places have been found for all clients except for those requiring hospitalization. The operator in the lodging scheme acts as a liaison link between the probation officer and the landlady, and when accepting a referral obtains as many facts and impressions of the client as are necessary to suggest a lodging situation compatible with that client's

needs. A wide range of lodging needs has been uncovered by the program including noncommercial accomodation for the mentally ill and addicted, and the development of supportive community type homes for females with children.

Hombs, M.E., and Snyder, M. (1982). Homelessness in America: A forced march to nowhere. Washington, D.C.: Community for Creative Non-Violence. [HV4505 .H65 1982].

Advocacy based book calling for government and private action to aid the homeless. Useful as background but much more detailed material is now available.

Hope, M., and Young, J. (1984). From back wards to back alleys: Deinstitutionalization and the homeless. Urban and Social Change Review, 17(2), 7-11.

Posits a causal linkage between deinstitutionalization and homelessness. Attributes this linkage to the desire to have "efficient" and "cost effective" social services and the vulnerability of the client population. The clients are seen as being powerless to resist deinstitutionalization or to demand adequate community care.

Hopper, K. (1985). The making of America's homeless: From skid row to new poor, 1945-1984. New York: Community Service Society.

Traces the changing nature of homelessness in modern America. Concludes that the modern crisis has become chronic so that it is now "normal" to have a homeless segment of the population.

Hopper, Kim, Baxter, Ellen and Cox, Stuart. (1982) Not making it crazy: the young homeless patients in New York City. New Directions for Mental Health Services, June, No. 14, pp. 33-42.

Examination of the causes of the increase in the number of young people who are mentally ill and homeless. Suggests that "denied admissions", "revolving doors" and "non-reach" (i.e., lack of outreach activities) together lead to non-involvement with the mental health system and increased vulnerability to homelessness. Researchers suggest that without decent, safe, accessible shelter, therapeutic efforts are fruitless.

Kanskie, N. (ed). (1985). Poverty in Wisconsin: proceedings of a conference held Nov. 30, 1983. Madison: Applied Population Laboratory, University of Wisconsin-Madison. [HB 935 W6 W5 80-3].

Collection of recent papers. Notes that while Wisconsin is relatively wealthy (compared to the U.S.) the national trends of removal of low cost housing, higher unemployment and social service problems are also present.

Kasinitz, P. (1984). Gentrification and homelessness: the single room occupant and the inner city revival. Urban and Social Change Review, 17(1):9-14, Winter.

Examines the process whereby gentification removes low cost housing units from the housing market by "promoting" units through renovation to medium and high cost segments of the market. The downtown areas of many American cities have undergone extensive renovation and revitalization in recent years; this "back to the city" or "gentrification" movement has been both acclaimed as an urban renaissance and accused of destroying urban neighborhoods and displacing inner city residents. The author is concerned with the effect of the rapid increase in the desirability of city land on what is usually considered the least desirable housing stock in the country: single-room occupancy hotels, rooming houses, and shelters. While the author attributes at least part of the rise in homelessness to gentrification there is no evidence presented to link the removal of SRO housing etc with gentrification efforts.

Kates, B. (1985). The murder of a shopping bag lady. San Diego: Harcourt Brace Jovanovich.

Recounts the events in the life of a woman - an immigrant who worked at low paid jobs, never married, cared for her parents and petty criminal brother and was diagnosed schizophrenic, who was murdered in NYC. While her story is unremarkable, the book is essentially a case history - one of the few available.

Kaufman, N.K. (1984) Homelessness: a comprehensive policy approach. Urban and Social Change Review, 17(1):21-26, Winter.

The Massachusetts policy on homelessness involves activating all appropriate agencies (public and private) to actively serve the homeless. Long run activities (such as providing low cost housing) are initiated while short run emergency shelter is pursued. The author considers how Massachusetts has attempted to deal with the causes and effects of homelessness in as comprehensive a manner as possible. Massachusetts is seen to have adopted a decentralized inter-agency approach in order to ensure that the state's response to homelessness will be built on the special features of each geographic area of the state. The state sees its role as developing policies which aid local communities in filling the gaps as they become evident at the local level. While the role of the state is crucial, there are also roles for local government, United Ways, churches, and synagogues; the problem of homelessness is too complex for any one group to tackle by itself.

Komisar, L. (1977). Down and out in the USA: A history of public welfare. New York: New Viewpoints.

Traces the development of the modern welfare system in the

U.S. The major focus is the linkage between reform movements, welfare programs and increasing bureaucratization.

Kondratas, S.A. (1985). A strategy for helping America's homeless. Washington, D.C.: Heritage Foundation.

One of the few "Reganomics" statements on homelessness. The report suggests that private charity should be used for the "truly needy" while the undeserving should not be aided. Any long run solution is seen as coming from a "dynamic" "expanding" private sector providing jobs.

Lamb, R.H. (1984). Deinstitutionalization and the homeless mentally ill. Hospital and Community Psychiatry, 35, 899-907.

The author notes that deinstitutionalization has worked well but failures have occurred (some of the failures resulting in homelessness). Failures are of two kinds; 1) system failures where the community services necessary to support the person with mental illness were, not set up, poorly financed, poorly managed, or otherwise inadequate; 2) placement failures where the individual was inappropriately placed (ranging from "dumping", to inappropriate program placement).

Leaf, A., and Cohen, M. (1982). Providing services for the homeless: The New York City program. New York: Human Resources Administration. (250 Church St., NY, NY, 10013).

Leepson, M. (1982). The homeless: Growing national problem. Congressional Quarterly, pp. 795-812. [Editorial Research Reports, 2 (16)]

The steady growth in the number of homeless is seen as a result of social policies (deinstitutionalization, benefit cut backs, eligibility rule changes) and a weak economy.

LeGates, R.T., and Murphy, K. (1984). Austerity, shelter and social conflict in the United States. In W. K. Tabb & L. Sawers (Eds.), Marxism and the metropolis (pp. 123-151). New York: Oxford University Press.

Lincoln, S.J. (1980, July). Single-room residential hotels must be preserved as low-income housing alternative. Journal of Housing.

Author describes the portion of the housing market accessible to low income persons as facing losses from urban renewal, gentrification and conversion. The need to preserve. SRO , housing as an element of the low income housing stock stems from the need for various kinds of housing to meet the diverse needs and ability to pay of the very poor.

Locke, H.J. (1935). Unemployed men in Chicago shelters. Sociology and Social Research, 19, 420-428.

This study done at the height of the Depression provides a remarkable parallel to contemporary studies of destitute men.

Among the men studied average subpopulation was able and willing to work (%), another able but unwilling to work (%) while a third were unable to work (%).

Marcus, S. (1981). Financing residential hotel improvement: New York City. New York: Mayor's Office of SRO Housing. Committee on Banking, Finance and Urban Affairs (1983), Homelessness in America (No. 97-100). Washington, D.C.: U.S. Government Printing Office.

Presented as a proposal this plan involved creative financing options such as:
1) City purchase and renovation of properties with eventual "land over" to private charities.
2) Private renovation using city "grants" with guaranteed "contract of service" for shelter of the homeless.
3) "Rotting capital" where seec money would be used for the first renovations and cost savings or profits would form the basis for further renovations.

Maz, V., founder, House of Ruth, Washington, D.C. (1983). Committee on Banking, Finance and Urban Affairs, Homelessness in America (No. 97-100). Washington, D.C.: U.S. Government Printing Office.

Describes a large urban shelter/transitional facility for women in Washington, D.C. Women who enter the program have intensive case management to secure services, find housing and employment (if appropriate). A large proportion of the women have some form of mental illness. While the shelter is intended as an emergency and tarnsitional housing facility it has become part of the community support system.

Miller, R. (1981). The demolitior of skid row. Lexington, MA: Lexington Books.

The demolition of skid row was once (1960's) seen as inevitable and idea solution to the problem of substandard housing. While urban renewal removed much of the SRO and cubical hotels, incomes of the very poor have not risen sufficiently to enable the poor to attain significantly better housing.

Moore, Harvey A. and Yegidis, Bonnie. (1982) Nobody's clients: females, alcohol and skid row. Journal of Drug Issues, Sum. Vol. 12(3), pp. 251-258.

Interviewed a group of 45-69 yr. old women found on "skid row" (in Tampa, St. Petersburg, and Sarasota, Florida) and studied police arrest records over 1 mo. to examine the dynamics of this culture. SS' social identity seemed to be organized around their moral or sexual deviance, since they were looked upon as prostitutes rather than as vagrants or alcoholics. Research on female alcoholic patterns and the enduring presence of females on skid row is reviewed in light of the development of social services for this

subpopulation. (36 ref.)

Norton, R.D. (1983) Reindustrialization and the urban underclass. Hicks, D.A. and Glickman, N.J., eds. Transition to the 21st century: prospect and policies for economic and urban-regional tarnsofrmation. Greenwich, CT: Jai Press, 1983, pp. 181-203.

The single most critical test of central-city poverty, the author states, is federal urban policy. In spite of recent downtown revivals, the proverty count for central-city blacks rose by over one million people during the 1970s, signifying the failure of the dominant place-oriented urban strategy that has prevailed since the mid-1960s. A new strategy to fight urban poverty and underemployment can be effectively harmonized with the equality critical objective to revitalizing the American economy, the author contends; doing so, however, will demand a shift in empnasis from the useless place-orineted strategy to one of more direct assistance to distressed people--and that entails an end to both federal and local practices that currently link the underemployed to declining areas. The author calls for a people-to-jobs or mobility strategy that can serve two crucial purposes: (1) opening up new opportunities for the minority poor and for structurally displaced workers in general; and (2) serving the objective of enhanced flexibility--a heightened capacity to adapt to change--in the economy of the United States.

Otto, S., and Orford, J. (1978). Not quite like home: Small hostels for alcoholics and others. Chichester, England: John Wiley & Sons.

Reviews British models of housing. Falling between U.S. group homes and SRO accomodations. The small hostels are similar to small Y's. They provide some supervision and support but the emphasis is an accomodation rather than theraputic settings.

Overend, W. (1983, December 30). Mentally ill overtaking alcoholics on skid row. Los Angeles Times.

Notes that the number of mentally ill persons has grown to exceed that of the alcholics on skid row in Los Angeles. Many of the service agencies are consequently having to deal with a population with which they have little experience.

Patrick, J. (1979). Staff reactions to the closing of a community mental health center. Hospital and Community Psychiatry, 30, 259-262.

As budgets are constrained some communities are experiencing a re-centralization of community support programs. The staff of the centers that are closed show marked demoralization because they see the closings as a failure of the CSP model of treatment and with increasing work load are less able to serve their clients.

Parker, E.C. (1984). Medical care for the homeless. Journal of the American Medical Association, 252(6), 766.

The author notes that health care for the homeless is generally inadequate while the need is higher than in the overall population. The homeless present with both acute health care needs (trauma, exposure, etc.) and chronic problems (often severe due to lack of treatment). The need for innovative outreach and preventive care is discussed.

Pina, G.M. (1983). Housing is a right. Copenhagen: Royal Danish Academy of Art, School of Architecture, Foreign Students Department. p[HD7324.A3 P54 1983]

The author makes the case that housing is a human right. Housing in this case is seen as more than a shelter. Rather "housing" is defined as having some permanence and privacy.

Peterson, Iver. "Homeless Crisscross U.S. Until Their Cars and Their Dreams Break Down." New York Times, December 15, 1982, p. A16.

Documents the group of people (usually young unemployed, often families) who drive from one city to another seeking work. When their car breaks down, they are stranded often hundreds of miles from their origin community.

Priest, Robert G. (1978) The epidemiology of mental illness: illustrations from the single homeless population. Psychiatric Journal of the University of Ottawa, March, Vol. 3(1):27-32.

Epidemiological studies have consistently shown high rates of mental illness (particularly schizophrenia) in the centers of cities and in association with low socioeconomic status. It was predicted that there should be excessive psychiatric morbidity among the single homeless population. This was confirmed (by clinical judgement, the symptom-sign inventory, and the brief paired associate learning test) in 79 SS from this population in Edinburgh (with schizophrenia the most frequent diagnosis) and in 50 SS from Chicago (where alcoholism was more common). A sample of homeless men presenting to Edinburgh hospital services predominantly displayed severe personality disorder, and was younger, mobile, and generally unrepresentative of the general homeless population. Other studies are discussed in relation to the conclusion that the epidemiological findings on schizophrenia demonstrate the effect of the illness rather than highlighting its causes. (40 ref.)

Reckless, W.C. (1934). Why women become hoboes. American Mercury, 31(February), 175-180.

This depression study indicates that women become homeless transiets either 1) as part of a couple where both are unemployed, or 2) as a single woman who, because unemployed or lost her economic support (usually through family

dissolution).

Rhoads, Joanne. (1981) Rainbow Retreat, Inc., Phoenix, Arizona. Matlins, S. Services for Children of Alcoholics, Washington, GPO, DHHS Pub., No. (Adm) 81-1007, 191 p. (p. 164-176).

Services offered by Rainbow Retreat, Inc. in Phoenix, Arizona, which was opened in 1973 as an emergency shelter for abused wives and children in alcohol related situations, and which have been expanded to permit acceptance of those fleeing any abusive circumstances, are described. A primary alcoholism prevention program provides support and guidance through one-to-one and group activities for youth involved in alcoholic environments, offers young people group experiences in communication and self-understanding; provides parents guidance and education in effective parenting techniques, and shelter for children and motehrs who have experienced alcohol abuse within their families. Programs for residential, daycare, and drop-in clients include individual counseling, rap sessions, art and music activity groups, story time groups, and structured play. The residential shelter and treatment programs for abused or neglected children is designed to provide a family atmosphere and positive environment as a model for changing behaviors, attitudes, and values. The main goal of this component is to keep the family together as a unit, often with the women as head of household. Elements of the daycare program and community youth groups are examined, as are factors that should be included in program/client evaluation and design.

Ribton-Turner, C.J. (1887). A history of vagrants and vagrancy and beggars and begging. London: Chapman and Hall.

Perhaps the most influential book of the period. It summarized the development of the British treatment of the destitute and the then (1880's) position in Britain. This book provided the intellectual "backbone" of the reform movements (both U.K. and U.S.) of the 1890's. Coupled with "advocacy" publications, such as Booth, it provided a rationale for change so clearly indicated in the "advocacy" documents.

Riis, J.A. (1890). How the other half lives. Republished with introduction 1970, ed S.B. Warner. Belknap Press of Harvard U.P.

Based primarily on New York City this strongly argued book was a major factor in the housing and poor refore movements of the 1890's. By presenting the human consequences of inhuman living conditions, Riis communicated to the urban middle class the urgency of the situation. Many of his recommendations (tennement reform, sanitation, building codes, etc.) were later enacted in major American cities.

Rooney, James F. (1976) Friendship and disaffiliation among the skid row population. Journal of Gerontology, 31(1):82-88.

Studies of social relations of skid row men which have utilized theories of complete disengagement and of replacement of old friends by new are discussed. Data from interviews with 304 Philadelphia skid row residents upheld the theory of replacement. There was, however, a decline in the number of friends reported after the age of 70 and after 20 years of residence in the area. The loss of relationships was more closely associated with length of residence in skid row than with age. Qualitative measures of personal relationships indicated no major association between sociability and length of residence in skid row but a small association with advancing age. The proportions of friendless men desiring either friends or causal acquaintances were not related to either age or length of residence. It is concluded that these findings fail to uphold the disaffiliation hypothesis of aging and run counter to Vexliard's postulate of loss of need for meaningful personal relationships with increased exposure to the life of an outcast. (23 refs.) (Author abstracted modified.)

Rooney, J.F. (1980). Organizational success through program failure: Skid row rescue missions. Social Forces, 58(3), 904-924.

Author posits that skid row missions become organizational success by having programs that fail. The users of these failed programs become an ongoing pool of clients which keep the programs active.

Rosnow, M., Stapleton Concord, C., and Shaw, T. (1985). Listening to the homeless: A study of homeless mentally ill persons in Milwaukee. Final report of the Milwaukee Homelessness Research Project.

An extensive study of mentally ill homeless people in Milwaukee, including a comparison with a similar group who were involved with a community support program.

Rousseau, A.M. (1981). Shopping bag ladies: Homeless women speak about their lives. New York: Pilgrim Press.

This book includes photos and interviews with women who are homeless in New York City. It documents how they came to be homeless as well as their daily living strategies.

Reich Robert and Siegel, Lloyd. (1978) The emergence of the bowery, as a psychiatric dumping ground. Psychiatric Quarterly, 50(3):191-201.

The rising number of former mental patients in the decaying bowery section of New York following the drastic reduction of the New York state hospital population in the last decade which led to a demographic relocation of the mentally ill, rather than any real decline in the rate or severity of mental disorders, is described. Unable to function on their

own in society and without adequate supportive facilities available, many discharged patients live in the streets and eventually end up on the bowery, where they are carried for at the men's shelter. Studies have shown that over 50% of the current bowery population has a history of mental illness and that alcoholism is often a secondary, rather than primary diagnosis. The most frequently encountered diagnostic syndromes are mentioned and commented upon. Possible alternative treatment interventions are suggested. (4 ref.) (Author abstract modified.)

Salerno, D., Hopper, K., and Baxter, E. (1984). Hardship in the heartland. New York: Community Service Society of New York, Institute for Social Welfare Research. (Detroit, Cleveland, Cincinnati, Milwaukee, Madison, Chicago, Denver, Tulsa). [HV4045.5.A14 S25 1984]

Scott, N.J., and Scott, R.A. (1980). The impact of housing markets on deinstitutionalization. Administration in Mental Health, 7(3), 210-222.

Segal, Steven P., Baumohl, Jim, and Johnson, Elsie. (1977) Falling through the cracks: mental disorder and social margin in a young vagrant population. Social Problems, 24(3):387-400.

A study was undertaken in order to investigate the incidence of psychiatric disorder and treatment of a distinctive, emerging young vagrant population. Twenty-two percent of a young vagrant population reported on in this study, and believed to be representative of similar groups in many American cities, have been hospitalized for psychological disorder. These young mentally disordered vagrants are the most marginal members of the vagrant subculture, lacking social margin (i.e., resources, relationships, and a credible identity) with their families, community services, and their peers. Their critical lack of social margir is due to an incongruence of expectations between disordered vagrants and potential benefactors. This incongruence generates a situation in which apparently eligible clients fall or slip through cracks in the service system. Ultimately, these individuals will become the core of a new chronically disordered and dependent population housed, at best, in community based sheltered living arrangements as they grow older. (Author abstract.)

Segal, Steven P. and Baumohl, Jim. (1980) Engaging the disengaged: Proposals of madness and vagrancy. Social Work, 25(5):358-365.

The characteristics, problems, and obstacles to humane community care of the chronically dysfunctional deinstitutionalized mental patient are discussed with reference to a California field study of "street people". These cases represent that portion of the expatient population which is characterized by delusionary, unpredictable, and unreliable behaviors, minimal occupational skills, and consistently poor judgement in

financial management and interpersonal relations. Six conditions constitute significant obstacles to the community reintegration and care of space cases: transience, burden to the community chosen, inappropriate services, negative public attitudes, their proneness to victimization often involving violence, and chronicity. Recommendations for dealing appropriately with these obstacles are presented which could enhance the social integration of such cases through the development of stabilizing social supports that will function in lieu of distrupted social networks.

Smith, A.C. (1975). Desperate admissions. World Medicine, 10(13), 92-93.

Discusses the role of hospitals as providers of shelter to individuals with non-acute health care needs. Considers the advisability of "desperate admissions" sought by some homeless people.

Smith, J.C., and Hanham, R.Q. (1982). Deinstitutionalization and community acceptance of the mentally ill in the U.S.A. Ekistics, 49, 358-368.

Author discusses the resistance to mentally ill persons and facilities in U.S. communities.

Sommer, Robert and Osmond, Humphry. (1981) Journal of Orthomolecular Psychiatry, 10(3):193-201.

Results of deinstitutionalization of former mental patients are examined. Too often, it is argued, reformers followed the cry to shut down the large ineffective state hospitals, but not the demand to replace them with small active treatment community programs. Rather, the communities to which the former mental patients are released are not their original communities, but economically marginal areas where support services are not available. Cases are cited of former mental patients committing murder following their deinstitutionalization. Often, it is noted, these people should not have been released from mental hospitals, and yet, following their crimes, they will be incarcerated in jails with no mental health services. The closing of state mental hospitals has led to the crowding of jails and prisons with former mental patients or those who need mental health care. It is proposed that psychiatric reformers should direct their attention to the plight of the impaired street people and the mentally disturbed in jail.

Stern, M.J. (1984) The emergence of the homeless as a public problem. Social Service Review, 58(2):291-301, June.

During the 1980s, homelessness emerged as a significant public problem. Much confusion exists about the nature of this problem, who the homeless are, and what can be done about them. The author addresses these questions from an unusual perspective. Rather than concern for the facts

about the homeless, he is concerned about how the homeless have been conceptualized in the public's mind and what this tells us, not about the homeless, but about ourselves, our officials, and our society. He uses the homeless as a means of looking at our society. First, he examines the past two years to see how the homeless have become a public problem at the national level, and as a local issue in the city of Philadelphia. Second, he places the homeless in a historical perspective and speculates about the historical significance of the emergence of this issue. He argues that the homeless as a public problem reflect the conservative drift in public policy symbolized graphically by the Reagan administration's attack on the poor.

Stapleton Concord, C., Barry, B., Schwichtenberg, R., and Hagerman, C. (1985). Homeless in an All-American City: Report of the Shelter the Homeless Task Force of the Madison Urban Ministry.

Reports on a drop-in shelter in Madison, in the Winter of 1984-85, which emphasized a "soft entry" approach to linking homeless people with services.

Stoner, M.R. (1984) An analysis of public and private sector provisions for homeless people. Urban and Social Change Review, 17(1):3-8, Winter.

Homelessness is an old and malignant problem in the United States which has reached critical levels in virtually all major cities; it has been reported that there are 36,000 homeless people in New York City. The number of homeless people has swelled tremendously with the recession/depression and drastic cutbacks in publicly funded social services. Homelessness may be a permanent and to some extent untreatable problem, but that hypothesis cannot be tested while existing public and private welfare policies preclude there being sufficient service delivery for the homeless population. The author reviews the types of programs that have arisen, or existed prior to the public outcry against homelessness in 1981 (with the publication of the New York City figure), to deal with the problem. A range of explanations about who the homeless are is offered, along with what appear to be the causes of their condition. Recommendations are made for a systematic approach to meet the homeless people, and an assessment is made of recent government attempts at solutions to the problem.

Test, M.A., and Stein, L.I. (1978). Community treatment of the chronic patient: Research overview. Schizophrenia Bulletin, 14(3), 350-364.

Description of the Dane County PACT program which includes intensive and agressive outreach with training in community living.

Urban Underclass, The. Society 21(1):34-86, Nov./Dec. 1983.

Wallich-Clifford, A. (1976). Caring on skid row. Dublin: Veritas.

One of several books documenting the Simon program of rehabilitating "destitute" individuals. The program is based on small housing units where the individuals are a mixture of residents and caretakers, but with a strong goal structure (which includes eventual placement in permanent independent housing - if appropriate). This program is not unlike the Dorothy Day Houses program in the U.S. in the 1940's and 1950's.

Williams, R.M. (1977). From bedlam to chaos: Are they closing the mental hospitals too soon? Psychology Today, 10(12), 124-129.

Author suggests that there is still a role for mental hospitals and that permature closing may lead to expensive re-opening in the future.

Watson, S. (1986). Housing and homelessness. London & Boston: Routeledge & Kegan Paul.

States. Urban scholars such as William Julius Wilson, Elijah Anderson, John D. Kasarda, Ira Katznelson, William Darity, Jr., David Whitman, Diana M. Pearce, and John U. Ogbu discuss such issues as racial and class boundaries, female poverty, changes in the employment base of cities, politics in the cities, education, immigrant populations, and inner-city dislocation. In an introduction entitled Inner-City Woes, William J. Wilson points out that since 1970, public attention to the problems of the inner-city has waned and that by the close of the twentieth century, the current problems of social dislocation will lead to a potentially explosive situation in the United States. In spite of a period of unprecedented civil rights activity and antidiscrimination legislation and socioeconomic position of the urban underclass has deteriorated. This suggests that the impact of forces not specifically race related need to be considered. Several authors argue that social organization is a strong factor in the problems of the under-class.

U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs, Subcommittee on Housing and Community Development. (1983). Homelessness in America (Report of hearings held December 15, 1982, Serial No. 97-100). Washington, D.C.: U.S. Government Printing Office.

This report of the first major hearing in the 1980's, contains many city reports reprinted as part of the submissions.

U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs, Subcommittee on Housing and Community Development. (1984). Homelessness in America II (Report of hearings held January 25, 1984 and appendices, Serial No. 98-64). Washington, D.C.: U.S. Government Printing Office.

Follow up to the 1982 hearings this report again contains many individual city reports.

U.S. General Accounting Office. (1985, April 9). Homelessness: A complex problem and the federal response [Report]. Washington: Author.

A review of individual city studies completed between 1980 and 1983.

U.S. Conference of Mayors. (1984). Homelessness in America's cities: Ten case studies. Washington: Author.

Wallace, S.E. (1965). Skid row as a way of life. New York: Harper & Row.

Based primarily on participant observation, this stuoy includes material on Minneapolis. The author seems to both document and explain skid row in terms of the "deviance" and/or "failure" of the individual.

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